

**Child Fatality Review #08-08**  
**Region 6**  
**Thurston County**

This 11-year-old medically fragile Caucasian male died from acute bronchopneumonia.

**Case Overview**

On July 17, 2008, staff at the Thurston County Health Department informed Children's Administration (CA) staff of the death of this 11-year-old boy. He passed away on January 9, 2008. CA staff were unaware of this child's death until notified by the county health department. The child was medically fragile and had Lissencephaly: a rare brain malformation characterized by the absence of normal convolutions (folds) in the cerebral cortex and an abnormally small head. Children with Lissencephaly rarely live beyond the age of five and often die from aspiration of food or fluids, or from respiratory disease. He was fed through a feeding tube and was developmentally delayed. The official cause of death is listed as bronchopneumonia. The child's pediatrician reported this child far outlived his life expectancy and that his parents did a good job providing care for him. The department was previously involved with this child's family due to referrals regarding the alleged filthy condition of the family home. There were no child abuse and neglect allegations in relation to this child's death. The department did not have an open case on this child or this family at the time of his death.

**Referral History**

On November 18, 2004, a social worker from the Division of Developmental Disabilities (DDD) reported to CA intake that the deceased child, then age eight, appeared extremely malnourished. This DDD social worker visited the child and found the child's feeding pump was not hooked up. The deceased child spent all day on a low cot mattress close to the floor. The feeding tube was on the floor and the floor was very dirty. The mother reported her son received five cans of Pediasure during the day. His room smelled strongly of urine. The floor to his room was covered with debris. This referral was screened as low risk for Child Protective Services (CPS) and referred to the Alternate Response System (ARS).

On December 1, 2004, the ARS provider working with this family contacted CA intake with concerns. The child's bedroom smelled of urine and a dirty diaper was lying on the floor. The bedroom floor was covered with garbage and toys. The child's bedding area was in the corner of a room on the floor and the room was cold. His mother reports that the room is one of the colder rooms in the house. She reported the child's condition was terminal and he outlived his life expectancy. The ARS worker believed the child was left to lie in bed most of the day and that his contact with the rest of the family was minimal. This referral was investigated by CPS and closed with an unfounded finding.

On October 19, 2005, a teacher reported the deceased child, then 9-years-old, had a sore on his left thigh approximately five inches long. The sore looked like a burn or a blood blister. The child returned to school after being absent since October 5<sup>th</sup>. The child was non-ambulatory and non-verbal. The child's mother said she had no knowledge of this sore. The sore appeared older than 24 hours. This referral was investigated by CPS and closed with an inconclusive finding.

On November 16, 2005, school staff reported the deceased child had sores on his back which were bleeding and oozing. There was no indication the sores were suspicious in nature. It was unknown if these sores were the same sores mentioned in a prior referral. This referral was screened as low risk CPS and no finding was required.

On December 8, 2005, a school bus driver reported to CA intake the deceased child was left outside in the cold waiting for the bus in his wheelchair. This referral was screened as information only.

On October 18, 2006, a social worker from DDD reported to CA intake that the deceased child, then age 10, weighed 32 pounds. He had scars from heeled pressure sores. A nurse was sent out to the home and found nothing to report regarding the deceased child's skin condition. This referral was screened as information only.

On October 25, 2006, a social worker from DDD reported to CA intake ongoing concerns about the deceased child. He was blind, non-functioning and heavily contracted (curled up in a fetal position). The mother was not following through with appropriate medical care. The mother reported her son was seen by doctors at Children's Hospital and Mary Bridge Hospital. Staff at both hospitals denied treating this child in the recent past. The deceased child was seen by a doctor at a local clinic in April of 2006 for problems with his gastric tube, feeding difficulties and seizure issues. This doctor asked the mother why her son was not on medications to address his contracting issues. The mother said her son's former doctor did not believe it was necessary. This former doctor was contacted and denied making this statement. The deceased child was on prescribed medication requiring regular checks of his blood levels. Those checks did not occur. The child's most current pediatrician said he saw no evidence of neglect and spoke positively of the mother's care for her son. This referral was investigated by CPS and closed with an unfounded finding.

On November 14, 2006, a social worker from DDD requested a child welfare check of the deceased child, then age 10. The social worker was concerned that the deceased child's parents were not caring for him appropriately. A deputy from Thurston County Sheriff's Office went to the home. The deputy noted that the home was messy, but did not appear to be unsanitary. The deputy noted a strong smell of urine in the home. The deputy found the deceased child connected to a feeding tube in his room. He appeared thin and pale. The mother told the deputy her son was to see his doctor in two weeks time and that CPS was involved with her family. This referral was screened as information only.

On November 16, 2006, school personnel called CA intake and alleged the deceased child was not properly buckled into his wheelchair, had bad body odor and bad oral hygiene. This referral was screened as information only.

On October 10, 2007, a relative reported she went to the home and found the deceased child's medication on the bathroom counter with the cap off and that at times she finds the medication in the deceased child's bedroom. The house was dirty. Bugs and fruit flies were present because of old food and garbage lying out. The refrigerator contained food that was expired and molded. The relative said she saw the home in this condition in May 2007 and was unaware of the condition of the home when she called intake five months later. This referral was screened as information only.

On October 22, 2007, a relative reported to CA intake she went to the family home on August 20, 2007. She stated the home smelled of urine and rotting food. The garbage, including food and dirty diapers, was overwhelming. She observed old food on the floor. Flies and gnats were visible on old food and in open food containers. There were dirty dishes scattered throughout the house. This referral was investigated by CPS and closed with an inconclusive finding.

#### **Issues and Recommendations**

**Issue:** None identified

**Recommendation:** None

